REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE DEPARTMENT OF HEALTH SERVICES COULD INCREASE ITS RECOVERY OF MEDI-CAL PAYMENTS BY $3 MILLION

P-566 DECEMBER 1986

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Telephone:
(916) 445-0255

STATE OF CALIFORNIA
Office of the Auditor General
660 J STREET, SUITE 300
SACRAMENTO, CA 95814

Thomas W. Hayes
Auditor General

December 1, 1986 P-566

Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the Department of Health Services' recovery of Medi-Cal payments. The report shows that the department could increase these recoveries by improving collection techniques and by implementing a federal law.

Respectfully submitted,

for THOMAS W. HAYES
Auditor General

TABLE OF CONTENTS

SUMMARY

RESULTS IN BRIEF

By implementing a recent federal law and improving procedures for recovering Medi-Cal payments, the Department of Health Services (department) could increase its recovery of Medi-Cal payments by an estimated $3 million annually. The department could increase its recovery of Medi-Cal payments from providers who should have been paid by Medicare by as much as $1.68 million. In addition, the department paid some providers more than they were entitled to because it did not meet a federal deadline in matching the medical service codes used by the Medicare and Medi-Cal programs. Since the department did not inform these providers that the payments were subject to recovery, the department jeopardized its chances of recovering these payments in the future. Furthermore, the department could increase probate collections by an estimated $493,000 annually. The department could also increase the recovery of Medi-Cal payments by an estimated $851,000 by limiting the eligibility of beneficiaries who transfer ownership of their principal residences and by imposing liens against these properties. Finally, the department does not ensure that it receives information on all beneficiaries who have other health coverage.

BACKGROUND

The department, through the Medi-Cal program, pays for health services for eligible beneficiaries and then attempts to recover these costs from liable third parties such as insurance companies or from beneficiaries' estates after they are deceased. The department relies primarily on county welfare departments and federal Social Security Administration offices to collect the information it needs to recover costs from liable third parties. During fiscal year 1985-86, the Medi-Cal program paid an estimated

$5 billion for health services; the State recovered more than $41 million from liable third parties, the estates of deceased beneficiaries, and other sources during fiscal year 1985-86.

PRINCIPAL FINDINGS

Some Providers Have Received Medi-Cal Payments to Which They Are Not Entitled

The department's Health Insurance Unit is responsible for retroactively billing providers who have received Medi-Cal payments for services that Medicare should have paid for. As of October 1, 1986, providers owed the department up to $2.25 million for billings dating as far back as October 1983. The department has informed these providers that they should seek reimbursement from Medicare and return the Medi-Cal payments they received to the State. While the department has also informed these providers that, if they do not return these payments, the department will offset the delinquent amounts against future claims for reimbursement, to date the department has not done this. As a result, $570,000 of the $2.25 million may no longer be recoverable. If the department does not execute its offset authority against these providers while they are still actively participating in the Medi-Cal program, it will become increasingly difficult to recover the remaining funds.

Overpayments Have Resulted From Not Matching Medi-Cal And Medicare Procedure Codes

Because the department did not match the medical service codes used by the Medicare and the Medi-Cal programs by a deadline the federal government established, the department paid $10 million more in payments to providers than was appropriate. The department did not inform these providers that excess payments were subject to recovery, and, therefore,

jeopardized its chance of recovering these payments in the future. In response to an audit by the State Controller's Office, the department indicated it had implemented the code matches needed to prevent this problem from reoccurring. However, during September 1986, the State Controller's Office discovered that some codes were still not matched and that inappropriate payments were still being made. The department does not consider these inappropriate payments to be overpayments and, therefore, does not intend to recover them. The State Controller's Office has requested the opinion of the State Attorney General's office on whether the department can recover these payments.

Additional Data Could Increase Recovery of Medi-Cal Payments From Estates Of Deceased Beneficiaries

The department is not using available information for identifying deceased beneficiaries who may leave recoverable assets in their estates. The Computer Sciences Corporation (CSC), the fiscal intermediary for the Medi-Cal program, maintains data that could be used to identify deceased beneficiaries. While the department presently uses many other sources to identify potential probate recoveries, the CSC data is sometimes more prompt and comprehensive. Our sample results indicate that the department could recover as much as an additional $493,000 annually if it included the CSC data as a means of identifying deceased beneficiaries.

Implementation of Federal Law Would Increase Recoveries

The department is neither imposing liens against principal residences of beneficiaries who receive long-term care services that are paid for by Medi-Cal nor limiting the eligibility of beneficiaries who transfer ownership of these residences. Consequently, Medi-Cal beneficiaries may transfer ownership of their principal residences to persons other

than spouses or dependents without jeopardizing their eligibility for benefits. This condition exists because the department has chosen not to implement optional provisions of the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which would allow the department to impose liens and limit eligibility without imposing undue hardships on beneficiaries or their families. We estimate that, by implementing this law, the department could recover as much as an additional $851,000 annually in the three counties we visited.

Beneficiaries With Other Health Coverage Are Not Always Identified

The department needs to ensure that it receives information on all beneficiaries who have other health coverage. While counties collect and forward this information to the department, the data are not always complete. As a result, the department cannot ensure that Medi-Cal pays for only those services for which there is no other coverage. The department could identify more beneficiaries with other health coverage by matching its computer tapes with those of insurance carriers, prepaid health plans, and health maintenance organizations. This practice, suspended since February 1985, has been facilitated by the enactment of Chapter 940 of the Statutes of 1986, which requires carriers to make this data available to the State.

RECOMMENDATIONS

To ensure that the State maximizes its recovery of Medi-Cal payments, the Department of Health Services should take the following actions:

- Develop formal procedures for recovering overpayments to providers who should have received reimbursement from Medicare;

- If the Attorney General's Office decides that the Medi-Cal overpayments resulting from unmatched procedure codes are recoverable, the department should immediately recover those overpayments for which recovery is cost effective;

- Use data available from the fiscal intermediary to identify deceased beneficiaries for potential probate cases;

- Implement the TEFRA, which will limit the eligibility of individuals who apply for Medi-Cal benefits when they transfer ownership of their residences to persons other than dependent family members; and

- Develop procedures to routinely conduct tape matches with carriers of other health coverage when it is cost effective to do so.

AGENCY COMMENTS

The department generally agrees to implement the report's recommendations.

INTRODUCTION

Medi-Cal, a $5 billion program jointly funded by the state and the federal governments, pays for health services for an average of 2.9 million eligible low-income Californians each month. The program, known as Medicaid in other states, is authorized by Title XIX of the Social Security Act and Section 14000 et seq. of the Welfare and Institutions Code. Title XVIII of the Social Security Act authorizes another health care program known as Medicare, a federal program for persons who are 65 or older and for other eligible persons. For fiscal year 1985-86, the State's share of Medi-Cal expenditures was approximately 49.2 percent, and the federal share, 50.8 percent.

Recipients of Medi-Cal services are known as beneficiaries. Applicants, who are screened by county welfare departments, qualify for Medi-Cal under one of three categories: the "categorically needy," persons who are public assistance recipients for whom coverage is required by Title XIX of the Social Security Act; the "medically needy," which includes families with dependent children, aged persons, blind persons, or disabled persons whose income and resources make them ineligible for public assistance but are insufficient for the cost of health care; and the "medically indigent," certain groups of persons who could not qualify under the first two categories for reasons other than income or resources but whose income and resources are insufficient for the cost of their health care.

Beneficiaries are entitled to a variety of health care services, including treatment by physicians, dental care, pharmaceutical services, inpatient and outpatient hospital care, and nursing home care. Providers of Medi-Cal services include individual practitioners, members of a group practice, or institutions such as hospitals.

The director of the Department of Health Services (department) administers the Medi-Cal program according to the terms and conditions of the State Medicaid Plan, an agreement with the Health Care Financing Administration of the U.S. Department of Health and Human Services. The department's primary Medi-Cal responsibilities are to ensure that beneficiaries receive medical services, to develop and disseminate Medi-Cal policies and regulations, and to control Medi-Cal expenditures. The department does not, however, directly process and verify the claims that providers submit for services to Medi-Cal beneficiaries. Instead, the department contracts with a "fiscal intermediary," a nongovernmental agency that processes and reviews claims for payment.

When Medi-Cal beneficiaries have other health care coverage, the Medi-Cal program makes the initial payment to providers for the beneficiaries' health care costs; then, the Recovery Branch, assisted by the county welfare departments and the federal Social Security Administration offices, identifies these cases and attempts to recover these payments. Under this system, which is known as "pay and chase,"

the Recovery Branch bills insurance carriers that are liable for services that Medi-Cal beneficiaries receive. Under a different system, known as "cost avoidance," the Recovery Branch ensures that the State does not pay for Medi-Cal services that beneficiaries receive if they are eligible for Medicare or if they are enrolled in a prepaid health plan or a health maintenance organization, which provide health care services for beneficiaries in exchange for prepaid or periodic charges.

Within the Recovery Branch, the Other Coverage Section uses Medi-Cal funds to pay the monthly premiums of Medicare insurance for Medi-Cal beneficiaries. By paying this premium, the State avoids paying for health care costs incurred by Medi-Cal beneficiaries who are also eligible for Medicare benefits. The Other Coverage Section also recovers payments from private insurance carriers that are liable for the services that some Medi-Cal beneficiaries receive. Under this "pay and chase" system, the department uses health insurance data compiled by the county welfare departments and the federal Social Security Administration offices to issue bills to responsible health insurance carriers. Federal regulations require the department to switch from its current "pay and chase" system for recovering payments to the "cost avoidance" system by 1986. Under the "cost avoidance" system, the department will still need to have information on all beneficiaries with other health coverage.

The Recovery Branch's General Collection Section files claims against the estates of deceased persons who received Medi-Cal benefits after reaching age 65 and have no surviving spouse or dependents. In addition, the section attempts to collect overpayments identified by units within the department's Audits and Investigations Division, the Department of Justice's Medi-Cal Fraud Bureau, and other sources. The General Collection Section recovers these payments from providers, beneficiaries, and responsible third parties either by demanding direct repayment to Medi-Cal or by having the fiscal intermediary deduct overpayments from pending and future claims providers submit for Medi-Cal payment.

The Recovery Branch also has primary responsibility for recovering unplanned overpayments and acts as the State's collection agent for recovering overpayments identified by a number of other organizations within and outside the department. For example, the department's Audits and Investigations Division audits payments to providers to ensure that the payments are appropriate. The division also investigates allegations of fraud against providers or beneficiaries and refers cases of fraud by providers to the Medi-Cal Fraud Bureau of the Department of Justice for further investigation and for possible criminal prosecution. The Payment Systems Audit Branch of the State Controller's Office audits the fiscal intermediary's processing of requests for reimbursement to ensure that payments reflect Medi-Cal policy and payment schedules.

The Recovery Branch estimates that during fiscal year 1985-86, it recovered more than $41 million in Medi-Cal overpayments and helped the State to avoid an estimated $1.3 billion in Medi-Cal costs by enrolling eligible beneficiaries in Medicare.

SCOPE AND METHODOLOGY

The purpose of our review was to evaluate the department's efforts to identify Medi-Cal overpayments and to maximize their recovery. During this audit, we reviewed statutes and regulations governing Medi-Cal recoveries as well as various records maintained by the department. In addition, we reviewed records at the welfare departments, assessors' offices, and recorders' offices in Los Angeles, Sacramento, and San Francisco counties. Approximately 42 percent of the State's Medi-Cal beneficiaries reside in these three counties.

To identify opportunities to increase recoveries, we analyzed a sample of 249 of the 898 delinquent accounts the department established for institutional providers who were reimbursed by Medi-Cal for services that should have been paid for by Medicare. To determine whether an additional source for identifying potential probate cases would increase recoveries, we reviewed a sample of 60 of 2,897 cases in which the fiscal intermediary had entered a code for a beneficiary over 65 indicating that the fiscal intermediary had authorized its final payment.

We reviewed approximately 300 case files for medically needy beneficiaries at each of the three county welfare departments to determine whether they had any other health coverage and whether the department knew of the other health coverage. We also reviewed between 73 and 138 case files for long-term care beneficiaries at each of the three counties to determine whether these beneficiaries were transferring ownership of their principal residences. In addition, we contacted officials in the State of Oregon to discuss their program for restricting these transfers. We also met with federal Health Care Financing Administration officials to discuss the possibility of implementing certain federal laws that would limit eligibility when beneficiaries transfer ownership of their residences.

Finally, we reviewed audit work the Payment Systems Audit Branch of the State Controller's Office conducted to determine whether the department paid providers more than was necessary in situations when both the Medi-Cal and the Medicare programs shared the cost of treatment. We did not, however, independently verify the accuracy of the audit by the State Controller's Office.

AUDIT RESULTS

I

INSTITUTIONAL PROVIDERS HAVE RETAINED MEDI-CAL PAYMENTS TO WHICH THEY ARE NOT ENTITLED

The Department of Health Services (department) has directed providers of institutional health service to return Medi-Cal payments to the State and to request reimbursement from the Medicare program when beneficiaries are eligible for Medicare; however, the department has not instructed the fiscal intermediary to deduct the appropriate amounts from the current and future Medi-Cal claims these providers submit for reimbursement. As a result, these providers owe the department up to $2.25 million, $570,000 of which we estimate may no longer be recoverable. In addition, when the department was unable to match all Medi-Cal and Medicare procedure codes in time to meet a federal deadline, it paid some providers more than they were entitled to receive. However, it did not notify providers that payments for unmatched procedures were subject to recovery in the future; thus, the department jeopardized the future recovery of these payments. The State Controller's Office estimates, and the department agrees, that since October 1984, the providers in question have received $10 million more than they are entitled to. While the department believes that it cannot recover these payments, the State Controller's Office has requested an opinion from the State Attorney General's Office on the State's ability to recover the $10 million. Finally, in October 1986,

the department notified providers that future payments may be subject to recovery if they are inappropriately high due to unmatched codes.

Medi-Cal Payments Not Recovered

According to the federal Health Care Financing Administration, Title XVIII, Section 1815(c), of the Social Security Act and the regulations that implement this statute allow the department to require providers to return Medi-Cal payments to the State and seek reimbursement from Medicare for services provided to beneficiaries who are eligible for Medicare coverage. When providers do not return Medi-Cal payments promptly, the department is authorized by Section 14177 of the Welfare and Institutions Code and by Title 22, Section 51047, of the California Administrative Code to recover the amount in question by directing the fiscal intermediary to offset the amount the provider owes the State against any pending or future claims the provider has submitted for Medi-Cal payment.

The Recovery Branch's Buy-In Unit operates an automated system that pays Medicare premiums for eligible Medi-Cal beneficiaries. By enrolling beneficiaries and paying their Medicare premiums, Medi-Cal avoids paying some of the cost for health care for these beneficiaries. Because Medicare coverage is available from the date a beneficiary is first eligible, the Buy-In Unit notifies the Health Insurance Unit to retroactively bill institutional providers who received Medi-Cal payments after the beneficiary's date of eligibility for Medicare and to instruct them to seek payment from Medicare.

Despite the department's offset authority, the Health Insurance Unit has not routinely taken action to offset providers' accounts. The unit does send two notices requesting payment. Although the second notice states that the provider's account will be offset if payment is not received in ten days, the unit does not conduct the follow-up activities needed to implement these offsets. The chief of the Other Coverage Section stated that, as of October 7, 1986, providers owed the department $2.25 million; some amounts have been outstanding since October 1983. While some of the providers in our sample may have returned these Medi-Cal payments by directly contacting the fiscal intermediary, the section's records contained no evidence that these payments had been recovered.

The longer the Health Insurance Unit delays before it requests that offset actions be taken, the less likely it is that Medi-Cal payments can be recovered. One reason for this is that providers may no longer be active participants in the Medi-Cal program. In addition, the chief of the General Collection Section has stated that accounts that are three or more years old are beyond the department's statutory recovery authority cited in Section 14172 of the Welfare and Institutions Code. However, the department is seeking a legal opinion on whether Section 14172 does impose this statute of limitations.

To determine how many of the delinquent accounts are still recoverable, we reviewed a sample of 249 of the 898 delinquent accounts the Health Insurance Unit has established since October 1983. Our

sample, representing $800,000, involved a total of 129 institutional providers that have received Medi-Cal payments. We estimate that the Recovery Branch could recover approximately $1,680,000 by offsetting the delinquent amounts owed Medi-Cal by providers who are still active in the Medi-Cal program. However, we estimate that the remaining $570,000 may not be recoverable because some providers are no longer actively participating in Medi-Cal and because the accounts of other providers may have exceeded the statute of limitations.

Some of the recoverable delinquent accounts are substantial. For example, one of the accounts in our sample involves a hospital that received $40,361 in Medi-Cal payments for services that should have been paid by Medicare. This hospital has been considered delinquent by the department since January 1984. We contacted the hospital's reimbursement manager, who stated that the hospital billed Medicare and asked the Medi-Cal fiscal intermediary to offset this payment in August 1983, but hospital records indicate that the offset action was never taken.

Some of the accounts for which recovery is now doubtful could have been offset if the Health Insurance Unit had acted earlier. For example, in one case, recovery of $155 may not be possible because the provider's ability to conduct business was suspended by the Franchise Tax Board 30 months after the department established the account. We also found two accounts totaling $275 in which recovery from hospitals is unlikely because there has been a change in ownership since the

department established the accounts. The new owners may not have assumed liability for the previous owners' debts.

According to the chief of the Other Coverage Section, offsetting providers' accounts is simple and costs only about $10; however, collecting payment from formerly active providers requires substantial effort by the General Collection Section. In all cases in which the department delays recovery efforts, even if an offset action can be taken, there is an additional cost to the State in foregone interest while the provider holds the money. For example, since January 1984, the $40,361 owed Medi-Cal by the first hospital noted above could have generated approximately $12,000 in interest at the rate earned by the State's Pooled Money Investment Account.

Furthermore, Medicare's fiscal intermediaries informed us that some of the providers in our sample have also received Medicare payments for the services in question. For example, a hospital that received $4,800 from Medi-Cal in February 1984 received $5,300 from Medicare for the same service in July 1985. Another hospital that received $3,300 from Medi-Cal in November 1983 received $3,100 from Medicare for the same service in October 1984. While Medi-Cal has considered both of these accounts to be delinquent since 1984, the Other Coverage Section's records indicate that neither of these providers has returned its Medi-Cal payments to the State.

There are three factors that have contributed to the Health Insurance Unit's failure to refer the delinquent accounts to the General Collection Section for offset action. First, the Health Insurance Unit does not have formal procedures to identify both the steps and the time required to recover the outstanding amounts. Second, the chief of the Health Insurance Unit has not officially assigned any staff the task of preparing the requests needed to offset the delinquent accounts. Third, although the chief of the Other Coverage Section has stated that he is aware of these delinquent accounts, he has assigned them a relatively low priority compared to the rest of the section's activities. However, he stated that he intends to initiate actions to recover payments on the delinquent accounts we reviewed.

Medi-Cal and Medicare Procedure Codes Not Matched

According to Section 14109.5 of the Welfare and Institutions Code, when a Medi-Cal beneficiary is also eligible for Medicare, Medi-Cal is to ensure that the total reimbursement to providers does not exceed the amount Medi-Cal would have paid for a medical service if the beneficiary had not been eligible for Medicare. For example, if Medicare's allowable cost for a specific service is $100, Medicare will pay the provider 80 percent, or $80. Medi-Cal, as the co-insurer, pays the provider a maximum of 20 percent of this allowable cost, or $20. However, if Medi-Cal allows only $90 for this service, the co-insurance payment is limited to $10 so that total reimbursement of $90 does not exceed what Medi-Cal would have independently paid for the service.

To ensure that Medi-Cal's fiscal intermediary can implement this payment limitation, the department's Medi-Cal Policy Division must match the codes the Medi-Cal program uses to represent medical services with the codes the Medicare program uses and then have the fiscal intermediary program its computer accordingly. Otherwise, the fiscal intermediary will not know the cost that Medi-Cal allows for a service and will automatically reimburse the provider 20 percent of the amount that Medicare allows.

In February 1983, the federal Health Care Financing Administration (HCFA) issued a conversion manual to notify the states that the Medicare program would be changing the codes it used to represent medical procedures. In January 1984, the HCFA repeated this message through a bulletin published by one of the Medicare program's fiscal intermediaries. The bulletin stated that this change would occur in October 1984. However, the Medi-Cal Policy Division was unable to complete all of the necessary matches by October 1984 when the new Medicare codes went into effect. In October 1984, the department issued a bulletin to providers stating that all procedures for which codes were not matched would be paid for by Medi-Cal at the full 20 percent co-insurance rate, regardless of Medi-Cal's allowable costs for these services. However, this bulletin, which the department authorized without consulting with its Office of Legal Services, did not stipulate that payments for unmatched procedures were subject to future recovery.

During its review of claims approved by the Medi-Cal fiscal intermediary, the Payment Systems Audit Branch of the State Controller's Office discovered that Medi-Cal's fiscal intermediary was routinely approving the full 20 percent payment for claims processed after October 1984. The State Controller's Office first notified the department and requested that the department correct the problem in August 1985. Further, since it considered these payments to be overpayments, the State Controller's Office asked the department to recover the $10 million in overpayments. The department responded that these payments resulted from a policy decision and were not actually overpayments. In addition, as we noted earlier, the department's bulletin did not inform providers that the payments in question were subject to future recovery. The State Controller's Office has requested an opinion from the Attorney General's Office to resolve this issue.

The chief of the Rate Development Branch stated that his branch matched the procedure codes as quickly as possible, to the extent that matches were feasible. The chief further stated that codes could not be matched sooner because of the amount of work involved, the complexity of the task, the lack of available staff qualified to do the job, and the relatively short notice the branch received for some of the proposed code changes. Instead, the branch assigned its staff qualified to match codes the task of ensuring that the overall Medi-Cal reimbursement system continued to operate effectively. However, the chief acknowledged that the Medi-Cal Policy Division did not consult

with the department's Office of Legal Services before informing providers that payments on unmatched codes would be made at the full co-insurance rate of 20 percent.

Although the department notified the State Controller's Office that it would have all medical procedure codes matched by May 1986, an audit by the State Controller's Office revealed that additional Medicare code changes were not matched promptly enough to prevent further unnecessary payments. The State Controller's Office estimates that, between March 1986 and August 1986, the State paid to providers $250,000 more than they were entitled to. It is uncertain whether the department can recover any of the overpayments attributable to these unmatched medical service codes.

In October 1986, the Medi-Cal Policy Division issued a second bulletin to inform providers that current and future payments may be subject to recovery if they are inappropriately high due to unmatched codes.

CONCLUSION

As of October 7, 1986, providers owed Medi-Cal up to $2.25 million for payments made by Medi-Cal for services to beneficiaries who are eligible for Medicare. Nevertheless, the Department of Health Services does not conduct the follow-up activities needed to deduct amounts these delinquent

providers owe Medi-Cal from later claims for Medi-Cal payment. We estimate that $570,000 of the $2.25 million may not be recoverable. The department has not initiated action to recover this money because it lacks formal procedures for doing so, because management has not assigned specific staff to the task, and because recovering this money has been assigned a low priority.

The department did not completely match all of the Medi-Cal and Medicare codes used to represent reimbursable medical services by a federal deadline. Because the department did not inform providers that payments for unmatched procedures were subject to future recovery, the resulting $10 million in excess payments to providers may not be recoverable. The department may have avoided this situation if it had consulted with its Office of Legal Services. In October 1986, the department issued a bulletin to notify providers that current and future payments may be subject to recovery if unmatched codes are identified in the future.

RECOMMENDATIONS

To ensure that Medi-Cal providers receive only those payments they are entitled to receive when the beneficiaries they treat are also eligible for Medicare, the Department of Health Services should take the following actions:

- Establish formal procedures that identify all steps necessary to promptly recover overpayments from providers who should have received reimbursement from the Medicare program. These procedures should include offsetting the amount owed against the providers' current or future claims for payment after the providers have failed to respond within a defined period. In addition, the department should immediately recover current overpayments by offsetting the amounts in question.

- Abide by the forthcoming opinion of the Attorney General's Office concerning the department's authority to recover Medi-Cal overpayments resulting from unmatched Medi-Cal and Medicare medical service codes. If the opinion indicates that these payments are recoverable, the department should take immediate steps to recover these payments whenever it is cost effective to do so.

II

THE DEPARTMENT OF HEALTH SERVICES COULD INCREASE ITS RECOVERY OF MEDI-CAL PAYMENTS FROM THE ESTATES OF DECEASED BENEFICIARIES

By using additional data available from the Medi-Cal fiscal intermediary and by implementing an optional federal law, the department could increase the amount of Medi-Cal payments it recovers from the estates of deceased beneficiaries by an estimated $1.34 million annually. The department is not using data available from the Medi-Cal fiscal intermediary that would help to identify more potential probate cases than it currently identifies. In addition, the department has chosen not to implement provisions of a federal law that would allow the department, in certain cases, to declare beneficiaries ineligible for Medi-Cal benefits when they transfer ownership of their homes to persons other than spouses or dependents.

Additional Data Could Increase Recovery of Medi-Cal Payments

The State's Probate Code allows the department to recover from the estates of deceased beneficiaries the Medi-Cal payments for services they received after age 65; however, certain time constraints apply. Section 700.1 of the Probate Code requires the heirs, the executor, the administrator, or the persons in possession of any property of a deceased beneficiary who had received Medi-Cal benefits

after age 65 to notify the director of the department within 90 days of the date of the beneficiary's death. This code section allows the department to file a claim against the estate no later than four months after it receives notice of the death when there is no surviving spouse or other dependents.

During fiscal year 1985-86, the Recovery Branch's General Collection Section recovered an estimated $7.7 million from the estates of deceased beneficiaries by using the following sources: notifications from attorneys and public guardians; data submitted by county welfare departments; data the federal Social Security Administration provides on deceased Supplemental Security Income/State Supplemental Program recipients; and newspapers that record legal notices. After the department reviews these sources, it sends letters of inquiry to the last-known addresses of deceased beneficiaries to determine if there are any recoverable assets.

However, the General Collection Section currently does not use data available from an additional source: the Medi-Cal fiscal intermediary. The fiscal intermediary produces computer data known as "long paid claims records," which show the date of Medi-Cal's final payment on behalf of a beneficiary and often indicate that a beneficiary has died. The fiscal intermediary currently makes this information available to the department's Data Systems Branch on computer tape. The Data Systems Branch uses these data for various purposes.

To determine whether the data on final payments could be useful in identifying deceased beneficiaries, we selected a random sample of 60 names from the long paid claims records for two months. Because Section 14009.5 of the Welfare and Institutions Code prohibits the department from filing a claim against a beneficiary's estate for services the beneficiary received before reaching 65, we restricted our sample to beneficiaries over 65. In 6 of these cases, either there was a surviving spouse or we could not determine whether the beneficiary had died. In 23 (38 percent) of the 60 cases, the General Collection Section had not sent out a letter of inquiry, indicating that the department had not yet learned from its usual sources that these 23 beneficiaries had died, even though an average of six months had elapsed. Further, by contacting the appropriate superior courts, we found that probate cases were pending for 2 of the 60 cases in our sample. While the chief of the General Collection Section stated that the department had already filed a claim against the estate of one of these beneficiaries, she also stated that the department was unaware that the second beneficiary had died. In this second case, the beneficiary died in January 1986, the court appointed an executor to the estate in April 1986, and the General Collection Section was still unaware of the death as of October 1986, eight months after the death occurred. Since receiving our information, however, the chief of the General Collection Section stated that the department will file a claim for $7,359.39 against the second beneficiary's estate.

In 31 (51 percent) of the 60 cases in our sample, the General Collection Section was aware that the beneficiary had died and had sent a letter of inquiry to the beneficiary's last-known address. However, even in these 31 cases, the department often would have learned of these deaths sooner from the data compiled by the fiscal intermediary. We found that the long paid claims records identified the deceased beneficiary an average of 30 days sooner than the General Collection Section's current sources. In 4 cases, the department would have been notified of the deaths at least 44 days sooner than it was notified through current sources. Early notification is important in probate cases because if attorneys distribute the assets and close an estate before the department files its claim, the department must attempt to recover Medi-Cal payments from the beneficiary's heirs. These additional recovery efforts are costly to the State.

The chief of the General Collection Section stated that long paid claims records have not been used to identify deceased beneficiaries because she was not aware that these data were available. The chief of the department's Data Systems Branch has stated that an automated system for using the data these records contain could be developed for the General Collection Section for an initial cost of approximately $16,000. This system could be operated for approximately $100 per month.

We believe that obtaining the long paid claims records would be worth these costs. By using the reports, the General Collection

Section could identify new cases with recoverable assets that it would not otherwise have identified. Using the rate we identified in our sample of 60 cases, we estimate that the section could increase recoveries by $493,000 annually. We base this estimate on the average amount of $1,700 that the section recovers from each estate it learns about through the Data Systems Branch.

Implementation of a Federal Law Would Increase Recoveries

When individuals apply for Medi-Cal benefits, they are asked if they own any real property or if they have transferred ownership of any property within the past two years. If the applicant becomes a beneficiary, inquiries concerning real property are made annually when the county redetermines the beneficiary's eligibility for Medi-Cal. Currently, principal residences are exempt from consideration when the county determines eligibility for benefits; other real property, however, is considered in determining eligibility for benefits.

The Federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allows states, in certain cases, to declare beneficiaries ineligible for Medi-Cal benefits when they transfer ownership of their principal residences. By transferring these properties, beneficiaries can prevent Medi-Cal from recovering payments from their estates through the probate process allowed by Section 14009.5 of the Welfare and Institutions Code. As specified in Section 1917(c)(2)(B)(i) of the Social Security Act, the TEFRA would allow the department to establish

a period of ineligibility for Medi-Cal if applicants transferred ownership of their homes for less than fair market value.

The TEFRA would not allow the department to impose a lien against a beneficiary's home if the beneficiary transfers ownership to a spouse; to a child who is under 21, blind, or disabled; or to a sibling who owns an equity interest and resides in the home. However, if a beneficiary transfers exempt property to any other person 24 months before he or she applies for Medi-Cal long-term care benefits or at any time after applying for Medi-Cal, he or she may be ineligible for Medi-Cal benefits for at least 24 months when the uncompensated value of the transferred home exceeds $12,000. According to the TEFRA, the period of ineligibility must bear a reasonable relationship to the uncompensated value of the transferred property.

The department currently does not impose liens against exempt property owned by beneficiaries under long-term care when these beneficiaries or the relatives who assume responsibility for them state that the beneficiaries intend to return to their homes. The TEFRA would allow the department to require beneficiaries and their physicians to prove that the beneficiaries can reasonably be expected to return home. If this cannot be demonstrated, the department could then file a lien against the beneficiary's exempt property. However, the amount of the lien cannot exceed the amount of Medi-Cal benefits the beneficiary received after age 65. If the beneficiary does return home, the lien is dissolved. Otherwise, the lien allows the State to

recover Medi-Cal payments from the estate of the beneficiary after the beneficiary dies, provided that none of the exceptional conditions allowed by the TEFRA exist.

To determine if beneficiaries who own or recently owned their residences transferred ownership of these residences to persons other than those allowed under the provisions of the TEFRA, we reviewed a random sample of 303 case files of beneficiaries under long-term care at the three counties we visited. Of these 303 beneficiaries, 19 (6.2 percent) either owned or had recently transferred ownership of their residences. Of the 19 beneficiaries we identified as property owners, some owned exempt property that the county and the State were not aware of because these beneficiaries had not included this information on their Medi-Cal applications.* In 6 (31.6 percent) of these 19 cases, the beneficiaries transferred ownership of their homes, without adequate compensation, to persons who would not qualify as allowable exceptions under the provisions of the TEFRA. In each of these 6 cases, the State could have either recovered Medi-Cal payments through probate action after the beneficiary died or avoided costs by declaring the beneficiary ineligible for a specific period of time. We also found several cases in which it appeared that beneficiaries might

*We have notified the department's Audits and Investigations Division about these cases because they may involve fraudulent Medi-Cal applications.

have owned or transferred property, but we could not verify these circumstances because the county assessors' and recorders' offices lacked conclusive data for identifying beneficiaries.

Following are examples of transfers that the TEFRA would not allow. A beneficiary in San Francisco County transferred ownership of a house in 1982, without receiving compensation, seven months before applying for Medi-Cal long-term care benefits. The house had an estimated market value of $35,000 and was not mortgaged. Data we obtained from the Medi-Cal fiscal intermediary indicate that Medi-Cal paid $35,051 for services for this beneficiary and could have either recovered some or all of this amount from the beneficiary's estate or avoided $35,000 in costs by declaring the beneficiary ineligible for Medi-Cal benefits for at least 24 months. However, since the beneficiary transferred the exempt property, Medi-Cal will no longer be able to recover this amount. In a second case, in 1984, a beneficiary in Sacramento County transferred ownership of an unmortgaged residence, without receiving compensation, to her daughter before receiving $3,844 in Medi-Cal long-term care benefits. This property had a market value of at least $82,000. As in the first case, the State could have either recovered some or all of the $3,844 from the beneficiary's estate or avoided $3,844 in costs by declaring the beneficiary ineligible for at least 24 months.

We also found 11 cases in which beneficiaries owned property in joint tenancy arrangements. Under state law, when two or more

persons own property in joint tenancy and one tenant dies, the deceased tenant's interest in the property passes free of any claims, including Medi-Cal claims, to the surviving tenant or tenants. In cases involving either unreported property or property owned in joint tenancy arrangements, the State could, by implementing the TEFRA, declare beneficiaries ineligible for Medi-Cal benefits if they transfer ownership of property to persons other than those allowed. By doing so, the State would increase its chances of recovering Medi-Cal payments after these beneficiaries, their surviving spouses, and qualified dependents are deceased. However, under no circumstances would beneficiaries, their spouses, or their dependents have to leave or sell the exempt property involuntarily.

The chief of the department's Medi-Cal Eligibility Branch offered two reasons why the department has not attempted to implement the provisions of the TEFRA. First, he stated that the language in the TEFRA is vague. Second, he stated that a United States District Court decision in 1982 prohibited the department from limiting the right of beneficiaries to transfer property. As a result of this decision, the department adopted its current policy of allowing long-term care beneficiaries to transfer exempt property without affecting their eligibility provided there is an intention to return home. More recently, however, the chief met with officials of the Health Care Financing Administration (HCFA) to obtain the HCFA's position on these issues. Also, the deputy director for medical care services stated that the department intends to propose legislation that would enable

the department to recover Medi-Cal payments from the estates of beneficiaries who own property in joint tenancy arrangements.

During our review, we also met with HCFA officials and obtained their written responses to our inquiries concerning the provisions of the TEFRA. The HCFA's associate regional administrator stated that the 1982 United States District Court decision does not prevent the department from implementing the provisions of the TEFRA. He stated that, in certain cases, the department could declare beneficiaries ineligible for Medi-Cal benefits if they transfer property and could impose liens against exempt property owned by long-term care beneficiaries. He further stated that, for such a change to occur, the department would have to submit to the HCFA an amendment to the State's Medi-Cal plan.

We also interviewed officials in the State of Oregon's Department of Adult and Family Services. The chief of the Estate Administration Unit stated that Oregon had implemented the TEFRA in 1982 and that this action had resulted in an increase in that state's recovery of Medicaid payments.

If the percent of beneficiaries in our sample who transferred ownership of exempt property to persons other than surviving spouses or eligible dependents reflects the overall level of this activity, California could significantly increase its recovery of Medi-Cal payments. Based on the six transfers of property we documented in our

sample, the amount of payments Medi-Cal made on behalf of the beneficiaries involved, and the estimated market value of the homes these beneficiaries transferred, we estimate that the State could recover an additional $851,000 annually in the three counties we visited if the department implements provisions in the TEFRA.

CONCLUSION

The Department of Health Services is not using all available data for identifying potential probate cases that could lead to the recovery of Medi-Cal payments from the estates of deceased beneficiaries. We estimate that, by using the long paid claims records available from the Medi-Cal fiscal intermediary, the department could identify more probate cases and would recover an additional $493,000 annually. In addition, the fiscal intermediary's records would sometimes inform the department sooner about the deaths of beneficiaries and make it easier for the State to promptly file claims in probate cases.

The department has chosen not to implement provisions in the TEFRA that would allow the department, in certain cases, to declare beneficiaries ineligible for Medi-Cal benefits if they transfer ownership of their homes. According to HCFA officials, the department could implement these provisions by amending the State's Medi-Cal plan. By implementing the

TEFRA, the State could recover an additional $851,000 in Medi-Cal payments annually without causing undue hardships for beneficiaries, their surviving spouses, or their dependents.

RECOMMENDATIONS

To ensure that the State maximizes its recovery of Medi-Cal payments from the estates of deceased beneficiaries, the Department of Health Services should take the following actions:

- Develop an automated system to use the long paid claims records issued by the Medi-Cal fiscal intermediary for identifying deceased beneficiaries and filing claims in probate cases; and

- Continue consulting with the HCFA on ways to amend the State's Medi-Cal plan so that the State can implement the provisions of the TEFRA that would allow the department, in certain cases, to declare beneficiaries ineligible for Medi-Cal benefits if they transfer ownership of their principal residences. These amendments should allow beneficiaries, their spouses, and their dependents to remain in their homes until all are deceased. If the department finds that changes in statutes are required to implement these amendments, the department should propose these changes to the Legislature.

III

THE DEPARTMENT OF HEALTH SERVICES DOES NOT ALWAYS IDENTIFY BENEFICIARIES WITH OTHER HEALTH COVERAGE

The department needs to ensure that it receives information on all beneficiaries who have health coverage in addition to Medi-Cal. While county welfare departments are required by law to collect and forward data on beneficiaries with other health coverage, the Recovery Branch does not always receive this information on all beneficiaries and, therefore, cannot ensure that Medi-Cal pays for only those services for which there is no other coverage. In addition, since February 1985, the department has not matched its computer tapes with those of health insurance carriers to identify Medi-Cal beneficiaries whose medical care should be paid for by the health insurance carriers.

Title 22, Section 50765, of the California Administrative Code requires county welfare departments to collect information from Medi-Cal beneficiaries on their other health coverage and to submit these data to the department. In addition, Section 14124.71 of the Welfare and Institutions Code authorizes the department to recover Medi-Cal payments from third parties that are liable for the Medi-Cal services that a beneficiary receives.

At the beginning of fiscal year 1985-86, the department, with the assistance of the counties and federal Social Security

Administration field offices, identified an estimated 125,000 Medi-Cal beneficiaries with other health insurance coverage. During the first nine months of fiscal year 1985-86, the Recovery Branch recovered an estimated $5.6 million from private health insurance companies. Also, the State avoided an estimated $1.3 billion in Medi-Cal costs by identifying third parties, including private insurance companies, prepaid health plans (PHPs), health maintenance organizations (HMOs), and the federal Medicare program, which were liable for the health care of Medi-Cal beneficiaries.

To ensure that Medi-Cal does not pay for medical services for beneficiaries who have other health coverage, the department must receive prompt and complete information from the counties regarding these beneficiaries. When the counties fail to identify beneficiaries who have other health coverage, the State may make unnecessary payments for beneficiaries who are covered by HMOs and PHPs but who receive services from providers who are not members of these groups. In addition, the department cannot recover Medi-Cal payments from health insurance carriers that are liable for the health care services the beneficiaries received.

Our audit revealed that the department does not always receive complete data from the counties on beneficiaries with other health coverage. We visited the welfare departments of Los Angeles, Sacramento, and San Francisco counties and reviewed, at each county, a random sample of approximately 300 current cases of medically needy

beneficiaries. Of the 941 total beneficiaries, 108 stated on their applications for Medi-Cal that they had other health coverage. While 40 beneficiaries in our sample stated that they were enrolled in a PHP or an HMO, the counties failed to enter the appropriate data into the Medi-Cal Eligibility Data System (MEDS), a state eligibility data base, for 17 (42.5 percent) of these beneficiaries. If the counties do not enter this information into the MEDS, the department could make unnecessary Medi-Cal payments. Under these circumstances, the department may not be able to recover Medi-Cal payments because PHPs and HMOs are not liable for the services of providers who are not members of these groups. In addition, 68 beneficiaries indicated they had health insurance, and in 4 (5.9 percent) of these cases, the counties failed to provide the department with any data for billing these third parties.

We shared the results of our findings at the counties with the chief of the Recovery Branch's Other Coverage Section, which trains staff at the county welfare departments on how to collect information on other health coverage. He stated that our results are similar to the findings of his section in the past. He believes that counties do not always collect and report information on other health coverage because eligibility workers have large caseloads and may not perceive the collection of data on other health coverage as a primary responsibility. He stated that, while the section will continue to train county staff, matching computer tapes with the organizations that provide other health coverage can be effective for identifying beneficiaries with additional coverage.

The department can augment the data it receives from the counties through other sources. During our review, we learned that the department has matched its computer tapes with those of insurance carriers, but it has not done so since February 1985. The most recent tape match the department participated in cost the State $115,000 and generated a projected annual savings of $3.6 million for the State, a benefit-cost ratio of approximately 31:1. Recently enacted legislation, Chapter 940, Statutes of 1986, requires every health care service plan, self-insured employee welfare benefit plan, disability insurer, and nonprofit hospital service plan to maintain a central listing of its enrollees and to make this information available to the State upon reasonable request. Computer tape matches with insurance carriers, PHPs, and HMOs could augment data on beneficiaries the counties supply and could result in reduced Medi-Cal payments for services that beneficiaries with other health coverage receive.

The chief of the Other Coverage Section stated that the department is developing a plan to implement computer matches.

CONCLUSION

The Department of Health Services needs to ensure that it receives complete information on all Medi-Cal beneficiaries who have other health coverage. As revealed by our review of three counties, the department often does not receive complete information either on beneficiaries who are enrolled in

prepaid health plans and health maintenance organizations or on those with health insurance. The department could increase its identification of beneficiaries with other health coverage if it increased its use of computer tape matches with prepaid health plans, health maintenance organizations, and private insurance carriers, as allowed by Chapter 940 of the Statutes of 1986.

RECOMMENDATIONS

To facilitate its identification of beneficiaries with other health coverage, the Department of Health Services should take the following actions:

- Issue a memorandum to the county welfare departments reminding them of the importance of prompt, comprehensive information on all beneficiaries with other health coverage;

- Make use of the provisions of Chapter 940, Statutes of 1986, and develop procedures to routinely conduct cost-effective computer tape matches with prepaid health plans, health maintenance organizations, and private health insurance carriers.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

for THOMAS W. HAYES
Auditor General

Date: November 24, 1986

Staff: Samuel D. Cochran, Audit Manager
Peter Allyn Goldstein
Paul W. Apfel
Eric R. Robbins
Thomas J. Wurtz

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1248

November 19, 1986

Thomas W. Hayes
Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

DRAFT REPORT P-S66

Mr. James S. Stockdale has asked me to respond to your letter dated November 13, 1986 concerning the Auditor General's Report entitled "The Department of Health Services Could Increase Its Recovery of Medi-Cal Payments by $3 million."

The Department's responses to the Report are provided below:

- Auditor General's Recommendation #1:

  Establish formal procedures that identify all steps necessary to promptly recover overpayments from providers who should have received reimbursement from the Medicare program. These procedures should include offsetting the amount owed against the providers' current or future claims for payment after the providers have failed to respond within a defined period of time. In addition, the Recovery Branch should immediately recover current overpayments by offsetting the amounts in question.

  Department of Health Services' Response:

  The Department concurs with the objective of the Auditor General's recommendation; however, it is not necessary to establish new procedures. The Department already has procedures to instruct the Medi-Cal fiscal intermediary to offset current claims in order to promptly recover overpayments from providers who should have received reimbursement from the Medicare program. Currently, correspondence to providers relative to Medi-Cal overpayment do contain well defined time periods for the return of Medi-Cal payments. In order to ensure implementation of a Payment Adjustment Notice (P.A.N) after the providers have failed to respond to the Department's correspondence, the Recovery Branch is reexamining its follow through mechanism and will adjust this procedure as appropriate. (1)*

  The P.A.N. procedure involves the transmittals of a notice directly from the General Collection Section to Computer Sciences Corporation. In the case of the overpayments identified by the Other Coverage Section which

*The Auditor General's comments on specific points contained in Department of Health Services' response begin on page 45.

resulted from the retroactive Medicare eligibility of certain aliens, these cases have recently been referred to the General Collection Section for immediate recovery by way of the existing offset procedures.

- Auditor General's Recommendation #2:

  Abide by the forthcoming opinion of the Attorney General's Office concerning the Department's authority to recover Medi-Cal overpayments resulting from unmatched Medi-Cal and Medicare medical service codes. If the opinion indicates that these payments are recoverable, the Department should take immediate steps to recover these payments whenever it is cost effective to do so.

  Department of Health Services' Response:

  The Department agrees with the Auditor General's recommendation. If the forthcoming Attorney General's opinion does, in fact, indicate that past uncorrelated crossover payments were overpayments and are recoverable, the Department will take steps to recover these payments.

- Auditor General's Recommendation #3:

  The Recovery Branch's general collection section should work with the Data Systems Branch to develop an automated system to use the long paid claims records issued by the Medi-Cal fiscal intermediary for identifying deceased beneficiaries and filing claims in probate cases.

  Department of Health Services Response:

  The Department concurs with this recommendation. Preliminary steps are being taken to develop a system to utilize such data for identifying deceased beneficiaries. As stated in the report, the proposed recommendation will cost $16,000 to develop and $100 per month to maintain. These costs will include development of an automated cross-match system of long paid claims records against the General Collection Section's current data sources to ensure duplicate estate questionnaires are not generated and record edits for decedents not meeting the criteria of the law for reimbursement (i.e., under age 65 and/or surviving spouse - the Department is currently in process of reviewing implementation of this procedure).

- Auditor General's Recommendation #4:

  The Medi-Cal Policy Division should continue consulting with the Health Care Financing Administration (HCFA) on ways to amend the State's Medi-Cal plan so that the State can implement the provisions of the TEFRA that would allow the Department, in certain cases, to declare beneficiaries ineligible for Medi-Cal benefits if they transfer ownership of their principal residences. These amendments should allow beneficiaries, their spouses, and their dependents to remain in their

homes until all are deceased. If the Department finds that changes in statutes are required to implement these amendments, the Department should propose these changes to the Legislature.

Department of Health Services' Response:

The Medi-Cal Policy Division will continue to work with HCFA to clarify federal policy in order to maximize recovery of Medi-Cal payments under California laws. When the federal policy differs from California law, the necessary changes will be proposed to the Legislature.

- Auditor General's Recommendation #5:

Issue a memorandum to the county welfare departments reminding them of the importance of prompt, comprehensive information on all beneficiaries with other health coverage.

Department of Health Services' Response:

The Department regularly provides training to county welfare departments in procedures to identify third party liability. In this training, the importance of this information is stressed. The Department will additionally issue an All County letter to reiterate the importance of identifying third party liability to achieve Medi-Cal savings.

- Auditor General's Recommendation #6:

Make use of the provisions of Chapter 940, Statutes of 1986, and develop procedures to routinely conduct cost-effective computer tape matches with prepaid health plans, health maintenance organizations, and private health insurance carriers.

Department of Health Services' Response:

The Department concurs with the objective of the Auditor General's recommendation; however, it is not necessary to establish new procedures. The Department already has procedures which were extremely cost effective in matching the Medi-Cal eligibility file with three major health insurance carriers. The Department's Report to the Legislature in 1985 indicated we were able to find over 20,000 beneficiaries with unreported health insurance coverage. This produced an annual savings of $3.6 million at a one time cost of only $115,000 Department staff are planning to rerun the tape match program with the same three major carriers during 1986/87 and then to expand the tape matching program to two to five of the next largest carriers during the following year. (2)

In addition to the Department's responses to the Auditor General's recommendations, we have prepared responses to two "Principal Findings." These are provided below.

- Auditor General's Finding:

  Because the Department did not match the medical service codes used by the Medicare and Medi-Cal programs by a deadline the federal government established, the Department paid $10 million more in payments to providers than was appropriate. The Department did not inform these providers that excess payments were subject to recovery, and, therefore, jeopardized its chance of recovering these payments in the future. In response to an audit by the State Controller's Office, the Department indicated it had implemented the code matches needed to prevent this problem from reoccurring. However, during September 1986, the State Controller's Office discovered that some codes were still not matched ant that inappropriate payments were still being made. The Department does not consider these inappropriate payments to be overpayments and, therefore, does not intend to recover them. The State Controller's Office has requested the opinion of the State Attorney General on whether the Department can recover these payments.

  Department of Health Services' Response:

  The Department disagrees with the Auditor General's audit findings that overpayments have resulted from not matching Medi-Cal and Medicare procedure codes. The Medicare/Medi-Cal crossover reimbursement system is working as designed and is responsible for a current rate of savings of almost $100 million annually. Since the crossover system was implemented in 1982, it has generated an estimated total savings of $426 million.

  The so called "overpayments" are in fact valid and correct reimbursements for deductibles and coinsurance levied by the Medicare program on Medicare patients who also are eligible for Medi-Cal benefits. Pursuant to Section 14109.5, Welfare and Institutions Code, the Department matches or correlates Medicare and Medi-Cal procedure codes, when feasible, to ensure that total payments by both programs do not exceed the established Medi-Cal reimbursement rate for the equivalent procedure. Not all Medicare procedures can be correlated; however, and many require extensive analysis before a reasonable correlation can be established.

  When it is determined that a Medicare code can be correlated, instructions are issued to Medi-Cal's fiscal intermediary to implement the necessary programming changes. Crossover claims received on or after the date of implementation are then subject to Medi-Cal's rate limitation for the newly correlated procedure.

If a Medicare procedure which has not been correlated is billed on a crossover claim, Medi-Cal pays the residual amount or unpaid balance up to the amount established by the Medicare program as their maximum allowance. The Department does not consider reimbursement of Medicare's deductibles and coinsurance in these cases as being excessive or inappropriate. Until a Medicare procedure has actually been correlated, there is no Medi-Cal reimbursement rate which can be applied to that procedure.

Establishing a correlation for a Medicare procedure is tantamount to establishing a rate for a Medi-Cal procedure. Once a new rate has been established, subsequent reimbursements are not allowed to exceed that rate. However, the Department does not have the authority to recoup from providers any payments that might have been made in excess of the new rate prior to its effective date. Such a retroactive application of policy has long been held to be illegal. In the Department's legal opinion, this same restriction on retroactivity applies to new procedure correlations.

The Department is fully aware of the potential savings from developing new procedure code correlations. Approximately 90 percent of all crossover claims are subject to correlations that have been developed to date. Every attempt has and will continue to be made to ensure that new and revised correlations are implemented as quickly as possible, consistent with available resources and expertise.

- Auditor General's Finding:

The Department is neither imposing liens against principal residences of beneficiaries who receive long-term care services that are paid for by Medi-Cal nor limiting the eligibility of beneficiaries who transfer ownership of these residences. Consequently, Medi-Cal beneficiaries may transfer ownership of their principal residences to person other than spouses or dependents without jeopardizing their eligibility for benefits. This condition exists because the Department has chosen not to implement optional provisions of the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which would allow the Department to impose liens and limit eligibility without imposing undue hardships on beneficiaries or their families. Based on our review, we estimate that the Department could recover as much as an additional $851,000 annually in the three counties we visited by implementing this law.

Department of Health Services' Response:

The Auditor General's discussion leading to the recommendation that the State implement TEFRA mixes several TEFRA provisions. For clarity, these provisions should be evaluated separately.

First, TEFRA allows states to impose liens on the real property of a beneficiary who is of any age, before his or her death, if the individual is in long term care and cannot reasonably be expected to be discharged and return home. However, for such a lien to be placed against the home (which may or may not be exempt), the following individuals must not be lawfully residing in that home: the individual's spouse, child who is under age 21 or is blind or disabled, or sibling who has an equity interest in the home and who was residing in the beneficiary's home for at least one year immediately before the date in individual was admitted to the institution. The amount of the lien is for the Medi-Cal claims correctly paid or to be paid for that individual.

State law (Welfare and Institution Code (W&IC) Section 14006(b)) and State regulations (Title 22, California Administrative Code Sections 50425 and 50428) permit a lien only when the former home would have been nonexempt but for the fact that a bona fide effort is being made to sell the property. (This is known as the "list and lien" provisions.) Recoveries under the lien provision thus can be made upon the sale of the home either prior to or after the beneficiary's death. However, state law makes the former home exempt whenever an individual subjectively "intends" to return home. Thus, as a practical matter, the "list and lien" provisions are easily circumvented.

Secondly, federal law allows states to recover funds for paid Medicaid claims from the estate of any individual who was 65 years of age or older when he or she received Medicaid. State law (W&IC Section 14009.5) expressly allows such probate recoveries.

However, for a recovery to take place under the lien or probate process, the beneficiary must own the resource at the time the lien is placed, or the resource must be part of his/her estate at his/her death. Under California and federal law, it has been argued that when property is held in joint tenancy with two or more persons, and where one person dies, the deceased tenant's interest in the property passes free of any claims, including Medi-Cal claims, to the surviving tenant or tenants. SB 2594, a Department sponsored bill, was introduced in the last Legislative session which would have clarified the law concerning recovery of Medi-Cal claims notwithstanding joint tenancy provisions. This bill failed to pass. At this time, the Department has no plans to reintroduce the bill during the upcoming legislative session.

Under federal Medicaid rules, a transfer of assets rule may generally not be more restrictive than the rule under the Supplemental Security Income (SSI) program. Under SSI rules, an SSI recipient may transfer exempt property at any time without it affecting SSI eligibility. However, to facilitate estate recoveries in Medicaid, TEFRA allowed states to be more restrictive than SSI regarding transfers of the exempt home. As specified in Section 1917(c)(2)(B)(i) of the Social Security Act, the TEFRA would allow the Department to establish a period of

ineligibility for Medi-Cal in certain instances if applicants or beneficiaries transferred ownership of their homes for less than fair market value.

Specifically, if a beneficiary in long term care transfers his or her home to any person other than his or her spouse, child under age 21, child who is blind or disabled within 24 months before he or she applies for Medi-Cal long term care benefits or at any time after applying for Medi-Cal, he or she may be ineligible for Medi-Cal benefits for approximately 24 months $12,000. According to TEFRA, the period of ineligibility must bear a reasonable relationship to the uncompensated value of the transferred property. However, if a beneficiary in long term care is reasonably expected to be discharged from long term care and return home, TEFRA disallows a period of ineligibility. It is this language that appears vague and needs clarity in order to be administered. Previously, the Department sought to regulate the term "reasonably expected to be discharged" as part of the implementation of the "list and lien" provision previously described. Strong reaction to that provision caused the Legislature to specify under what circumstances a home or former home is exempt. These new provisions did not address or define the term "reasonably expected to be discharged."

The Department has not sought subsequent legislation to define "reasonably expected to be discharged." Without this definition, the Department would not be able to implement the TEFRA provision concerning ineligibility for some transfers of the exempt home. As stated, the Department is working with HCFA to clarify this area and when this occurs, necessary changes in statutes would be proposed to the Legislature.

As a final note, the Department would like to bring the following corrections to your attention. On page 3 of the Report, federal regulations (not statutes) require implementation of the "Cost Avoidance" system by 1986, not 1988. On page 5, the amount of funds recovered during 1985/86 fiscal year were $41 million, the report reflects an amount of $24 million. (3)

Thank you for the opportunity to comment on the draft audit report and we look forward to examination of the final audit report.

Sincerely,

Robert D. Crossgnant

for Kenneth W. Kizer, M.D., M.P.H.
Director

AUDITOR GENERAL'S COMMENTS ON THE HEALTH AND WELFARE AGENCY'S RESPONSE

1 We do not state that new procedures are necessary. Rather, we state that the department should formalize all procedures to ensure that all offset steps are carried through to completion. Currently, the Health Insurance Unit's manual contains no procedures for carrying out its responsibilities in the process. In its response, the department acknowledges that it "is re-examining its follow-through mechanism and will adjust this procedure as appropriate."

2 The department has not assured us that it has developed all necessary procedures to expand the computer match function. The needed procedures include those to integrate a well-planned and organized system into the routine recovery activities of the department, such as modifying computer software to include matches with prepaid health plans and health maintenance organizations as well as health insurance carriers. These procedures should also include those of an administrative nature such as contacting the organizations in question and arranging for points of delivery and storage of tapes and providing for legal custody of the materials.

3 We have changed the text to reflect the department's comments.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps